NOTE

This Microfiche meets the quality requirements of the American National Standard for Microfiche of Documents (ANSI PH5.9-1975). However, because of imperfections in the document from which it was made, it contains images that are illegible or difficult to read. The source document for this microfiche is the best copy that could be obtained prior to filming.

Congressional Information Service, Inc
Washington, D.C.

[COMMITTEE PRINT]

THE "BLACK BOX" OF HOME CARE QUALITY

A REPORT

PRESENTED BY

THE CHAIRMAN

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES
NINETY-NINTH CONGRESS
SECOND SESSION

PREPARED BY THE

AMERICAN BAR ASSOCIATION

AUGUST 1986

Comm. Pub. No. 99-573

Printed for the use of the Select Committee on Aging

This document has been printed for informational purposes only. It does not represent either findings or recommendations adopted by these Committees

U.S. GOVERNMENT PRINTING OFFICE

62-353 O WASHINGTON : 1986

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H142-8

SELECT COMMITTEE ON AGING

EDWARD R. ROYBAL, California, *Chairman*

CLAUDE PEPPER, Florida
MARIO BIAGGI, New York
DON BONKER, Washington
THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD, Tennessee
STAN LUNDINE, New York
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
BEVERLY B. BYRON, Maryland
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
RON WYDEN, Oregon
GEO. W. CROCKETT, JR., Michigan
WILLIAM HILL BONER, Tennessee
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
RICK BOUCHER, Virginia
BEN ERDREICH, Alabama
BUDDY MACKAY, Florida
HARRY M. REID, Nevada
NORMAN SISISKY, Virginia
ROBERT E. WISE, JR., West Virginia
BILL RICHARDSON, New Mexico
HAROLD L. VOLKMER, Missouri
BART GORDON, Tennessee
THOMAS J. MANTON, New York
TOMMY F. ROBINSON, Arkansas
RICHARD H. STALLINGS, Idaho

MATTHEW J. RINALDO, New Jersey,
Ranking Minority Member
JOHN PAUL HAMMERSCHMIDT, Arkansas
RALPH REGULA, Ohio
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
JAMES M. JEFFORDS, Vermont
THOMAS J. TAUKE, Iowa
GEORGE C. WORTLEY, New York
JIM COURTER, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
GEORGE W. GEKAS, Pennsylvania
MARK D. SILJANDER, Michigan
CHRISTOPHER H. SMITH, New Jersey
SHERWOOD L. BOEHLERT, New York
JIM SAXTON, New Jersey
HELEN DELICH BENTLEY, Maryland
JIM LIGHTFOOT, Iowa
HARRIS W. FAWELL, Illinois
JAN MEYERS, Kansas
BEN BLAZ, Guam
PATRICK L. SWINDALL, Georgia
PAUL B. HENRY, Michigan
JIM KOLBE, Arizona
BILL SCHUETTE, Michigan
FLOYD SPENCE, South Carolina

FERNANDO TORRES-GIL, *Staff Director*
PAUL SCHLEGEL, *Minority Staff Director*

This Report was prepared by Charles P. Sabatino, Associate Staff Director, the American Bar Association's Commission on Legal Problems of the Elderly.

CHAIRMAN'S FORWARD

Home care services, in the broadest sense, generally enjoy a good reputation and are key to the goal of giving dependent persons the opportunity to live on their own or with their families in the community. Yet, we hear anecdotal accounts from home care consumers and providers of unreliable and poorly trained aides, of questionable care techniques, and, in some instances, of abuse and neglect.

What is most disturbing is that we simply do not know how serious or widespread these problems of home care quality are. Nor do we have the means to adequately protect one of the most vulnerable of all consumer groups -- persons receiving care in the home, away from public and professional eyes. In these respects, the quality of care in the home is a "black box" -- a virtual unknown.

The decision to release this report, prepared by the American Bar Association (ABA), is a statement of the Committee's concern for the well-being of persons receiving home care and our intent to fortify the largely positive regard home care now enjoys. This concern is only heightened by the rapid increase in the use of home care services by our aging society, by the numbers and varieties of providers entering the home care market, by the growing public and private investment in home care, and by the impact of recent cost containment measures on access to and quality of home care.

The ABA is to be commended for their thorough and timely review of home care quality and the current system of standards and monitoring. The report is a critical first step in documenting the inadequacy of the present quality assurance system for home care and in recommending needed reforms. As such, it is a vital contribution to public policy and to public safety.

With this report and its recommendations in hand, it is now the responsibility of federal, state and local governments and the private sector to work cooperatively to create a system of quality assurance that ensures that all care provided in the home is of the highest quality possible and delivered in the best interests of the consumer and their family.

The Committee extends its appreciation to the ABA, to the report's author, Mr. Charles Sabatino and to the Staff Director of the ABA's Commission on Legal Problems of the Elderly, Ms. Nancy Coleman, for their fine work and cooperation in releasing this report. Thanks are also extended to Dr. Marvin Kaiser of Kansas State University for his assistance in the Committee's efforts to ensure the quality of care in the home.

Edward R. Roybal
Chairman

August, 1986

PREFACE

In 1978 the American Bar Association established the Commission on Legal Problems of the Elderly. The Commission was charged with examining the provision of legal services to the elderly, discrimination against the elderly, simplification of administrative procedures and regulations, issues involving long term care, home equity conversion and Social Security due process.

The Commission's interest in long term care has resulted in several studies which include a monograph, "Model Recommendations: Intermediate Sanctions for Enforcement of Quality of Care in Nursing Homes," and a Model Act Regulating Board and Care Homes. The work on quality assurance in home care emanates from a concern for the number of people receiving care in their own homes. The number is growing dramatically and there has been a public outcry to provide services for people outside of institutions. Older frail people are vulnerable and often need the help of organized assistance. The scandals in nursing homes and board and care homes over the last fifteen years have led the Commission to begin to look at home care quality assurance.

Other recent areas of interest to the Commission have been the adjudicatory process in Social Security, the education of the judiciary in handling guardianship cases, the expansion of legal services provided by the private bar and the legal aspects of home equity conversion. The Commission will continue to seek out additional areas of the law and the

public policy arena which affect the quality of life of America's older population.

John Pickering, Chairman

John J. Regan, Vice-Chair
Jacqueline Allee
Sara-Ann Determan
Arthur S. Flemming
Burton Fretz
Rodney N. Houghton
Edward F. Howard
Harold R. Johnson
Joanne Lynn, M.D.
Robert S. Mucklestone
Douglas W. Nelson
Samuel Sadin
James M. Shannon
Daniel Skoler

THIS REPORT HAS NOT BEEN REVIEWED OR APPROVED BY THE HOUSE OF DELEGATES OR THE BOARD OF GOVERNORS AND DOES NOT CONSTITUTE THE POLICY OF THE AMERICAN BAR ASSOCIATION.

This project was supported, in part, by award number G-HHS 90AM0112/01, from the Administration on Aging, Office of Human Development Services, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration on Aging policy.

CONTENTS

	PAGE
Chairman's Forward	iii
Preface	v
Contents	vii
CHAPTER I. INTRODUCTION: THE PROBLEM	1
CHAPTER II. THE BASIS FOR CONCERN	5
o The elderly and Disabled at Risk	
o Cost Concerns	
o The Changing and Fragmented Marketplace	
CHAPTER III. THE ELUSIVE CONCEPT OF HOME CARE QUALITY	22
o What is Quality?	
o Structure, Process and Outcome	
o Accountability to the Consumer	
CHAPTER IV. THE INADEQUACY OF THE CURRENT SYSTEM	29
o What are the Inadequacies?	
o What Quality Systems are Now in Place?	
o What Do Current Standards Cover?	
CHAPTER V. OPTIONS FOR ASSURING QUALITY CARE IN THE HOME	40
o The Challenge	
o The Underlying Tensions	
o Recommendations	
REFERENCES	50
APPENDIX: SUMMARY OF STATE REGULATIONS	57

CHAPTER I
INTRODUCTION: THE PROBLEM

How do consumers of home care services know they are getting the kind and quality of care they should be getting? The answer is simple, they have no way of knowing. The quality of care being provided to older and disabled persons in their homes today is a virtual "black box" -- an unknown both to the consumer and to policy-makers.

Why is this a concern? First and foremost is the vulnerability of persons receiving health care and personal support services in the home setting. Consumers in need of home care and their families face an utterly confusing array of changing services, a dearth of information on which to base expectations, and little control over what happens. Even more significant is the in-home location of services that makes their actual delivery essentially invisible and, therefore, largely beyond the easy reach of public or professional scrutiny.

Added to this is the fact that the need for home care and the number and variety of providers in the system have mushroomed in recent years. It is estimated that about 8 million persons in the United States needed assistance with personal care in 1985 -- 5.2 million of them were over age 65.[1/2/] Every month since 1960, an average of 149,000 persons have joined the ranks of the elderly. The total age 65+ population doubled between 1950 and 1980 and is expected to double again by 2020.[3/] The kinds of home care services needed by this burgeoning population run the gamut from essentially non-medical support services,

such as homemaker and chore services, to traditional nursing-based home health services, to newer, rapidly emerging hi-tech services, such as kidney dialysis, sophisticated forms of artificial nutrition, and cancer chemotherapy. These latter services were unimaginable in home care just a few years ago.

Looking at the growth of the home care industry, the number of home health agencies certified under Medicare increased by more than 50 percent between 1982 and 1984, reaching a total of 5,237 agencies by the end of 1984.[4] The greatest growth occurred in investor owned agencies with their number increasing 300 percent during that period. Proprietaries now make up more than 30 percent of Medicare certified agencies, up from less than 6 percent in 1979.[5] The total number of home care agencies -- both Medicare and non-Medicare -- is unknown, but estimates range as high as 10,000. With the rapid change in the number and variety of service providers, the configuration of services from state to state is consistent only in its inconsistency and fragmentation.

A further concern is the fact that the government and individuals are investing an enormous amount of money in home-based care. Home health care products and services grossed an estimated $9 billion in 1985, with expansion to $16 billion projected for 1990; 70 percent of the total is for services.[6] In 1982 Medicare spent $1.3 billion and Medicaid spent $495 million on home health. Other federal programs spent an estimated $950 million.[7] While constituting only about 3 percent of the overall Medicare budget, home health expenditures have

grown dram- atically under Medicare at an annual rate of 34 percent between 1974 and 1980. Since 1980, Medicare home health ex- penditures have doubled from $772 million to $1.5 billion in 1983.[8]

Despite this growing need for home care in the context of a growing industry, the government and consumers simply do not know what they are getting for their money, both in terms of the nature of services and, more importantly, in the quality of services. Neither public nor private sector home care services operate under truly effective quality standards, monitoring mechanisms, or enforcement mechanisms. As a result, there is little accountability for quality under present systems and little knowledge about the existence or extent of quality problems.

On the one hand, home care services bring enhanced opportunities for the elderly to live longer and independently in their communities. Yet, they also bring enhanced risks of poor care, unreliable services and outright neglect, abuse and exploitation. Anecdotal reports leave little doubt that all these problems exist but to what degree is unknown. Hard data simply are not available. What really goes on in the beneficiary's home day-by-day is unseen. The unfortunate truth is that quality concerns have taken a back seat today to a more visible crisis in costs and availability of care to the public. Budget deficits and public program cuts have pushed funding issues to the fore, despite the fact that these same cuts have a direct impact on the quality of care delivered.

To date, home-based care has been relatively free from the worst case, pat-

ient abuse horror stories that have periodically rocked institutional health care. Yet the home care industry is now in a position not unlike that of nursing homes twenty years ago when a period of unprecedented growth began. Some of the lessons learned in twenty years of attempting to ensure quality in nursing homes can be heeded now in home care before day-to-day problems fester into day-to-day horror stories.

This report takes just a first step in seeking improved systems of quality and accountability in home care by examining what is known and unknown about the current system of home care, identifying major inadequacies of the system, and outlining critical issues and options for quality assurance. Included at the end is an Appendix comparing selected aspects of state home care licensure laws.

Chapter II
THE BASIS FOR CONCERN

The Elderly and Disabled at Risk

With respect to in-home care, as in health care in general,[1] the most basic reason for regulating care and services is the consumer protection need. The complexity of products, services and delivery systems is so great that even perfectly healthy individuals are commonly incapable of exercising competent market judgments. The frailty and relative incapacity of home care clients makes this task immeasurably more difficult. More significantly, the in-home location of services makes their actual delivery virtually invisible and, therefore, largely beyond the easy reach of public or professional scrutiny.

The kinds and extent of quality problems in home-based care have never been systemmatically studied in any depth. Yet, officials, providers, advocates, and consumers contacted during the course of preparing this report, commonly recounted anecdotal experiences involving a range of problems, for example:

- Worker non-appearance, tardiness, or failure to spend the specified amount of time;
- Inadequate or improper performance of duties;
- Failure to perform duties;
- Attitudinal problems: insensitivity, disrespect, intimidation, abusiveness, etc.;
- Theft or financial exploitation;
- Physical injury: intentional or accidental.

The degree of incidence of these problems is unknown. Nevertheless, the risk has increased as the use of home care has increased. Home care services have literally mushroomed, due to both demographic trends and internal changes in the country's health care systems.

The need to reduce reliance on institutional long-term care and the advent of the Medicare Prospective Payment System or (PPS) for hospitals have put greater pressure on home health care. Demographically, we are expected to witness a doubling of the age 65+ population -- from 25.5 million to 51 million -- between 1980 and 2020. The elderly proportion of the U.S. population will increase from 11 percent to over 21 percent.9/

Moreover, the fastest growing subgroup of this elderly population is the age 85+ group, who are the segment of the population most in need of long-term care services. Their number will increase nearly four-fold between 1980 and 2030 -- from 2.2 million to 8.6 million.10/ The increase in just this 85+ population alone could fill a city the size of Chicago more than twice over.

Not surprisingly, the need for assistance with activities of daily living increases dramatically with age. Only 2.6 percent of persons age 65-74 need assistance with personal care compared to 31.6 percent of those age 85 years and over.11/ For the total elderly population in 1985, it is estimated that 5.2 million were mildly to severely disabled with a need for assistance and special aids to maintain independence. This figure is expected to reach 7.2 million by

the turn of the cen- tury, 10.1 million by 2020, and 14.4 mil- lion by 2050.[12]

These statistics by no means portray a complete picture of need. The non-elderly also play a major role in home care usage. Estimates of the number of non-elderly needing assistance with personal care range from between two to three million persons.[13] Moreover, the need for in-home care is not limited to only the disabled or chronically ill. Significant numbers of relatively healthy people make use of home care services on occasion because of short term illness.[14] Finally, the need for care does not automatically translate into use of formal services. Informal care, primarily by families, still constitutes 70 to 80 percent of the care to the disabled elderly requiring assistance with daily living activities.[15]

Cost Concerns

Another concern that has long influenced the regulation of health care arises from the considerable expenditure of public money on care and services, and the resulting need for fiscal accountability. Where care is heavily dependent on third-party sources of payment, both patients and providers have an incentive to overutilize.[16]

A common response to calls for increased federal coverage of home care is the claim that it will produce what is sometimes referred to as the "woodwork effect." That is, people needing home care, who have been managing with the help of informal supports, will appear "out of the woodwork" in far greater numbers than anticipated, because of the

availability of subsidized services, creating an unbearable financial burden on the government.

The government's fiscal interest is to limit usage and expenditures and to impose regulatory safeguards to ensure that services actually rendered are both cost-effective and appropriate to the needs of the consumer. This basis of regulation is intended to protect both the public fisc and the consumer, but the actual purposes served and the effects are frequently distorted by political and bureaucratic realities.

Critics argue that the real effect of such regulation is negative in that it actually narrows the range of providers, thus killing competition, limiting supply and raising costs. A counter argument is that some form of market protectionism is needed because legitimate providers need incentives to offer an appropriate range of services, some of which will be less profitable and some more profitable. To do this, providers commonly "cross subsidize" services so that the profitable balances the unprofitable. Without some form of market protectionism, it is argued that entrepreneurs will enter the market to "skim the cream" by providing only the most profitable services, and in the end, doing more harm than good to the consumer.[17]

Quality and cost goals are unavoidably intertwined; and, they unavoidably conflict in many basic respects. Unfortunately, in home care, as in other areas of health care, it may be said that, too often, funding dictates services rather than need dictating the services. And, in public debate, funding

issues overshadow questions of quality. For purposes of this examination of quality control, cost control issues will be addressed only secondarily to facilitate a clearer focus on quality issues.

The Changing and Fragmented Marketplace

Home care is a moving target for regulators. The industry is growing and changing rapidly; there is little uniformity in definitions of services and providers; organizational forms vary considerably; and fragmented funding has produced fragmented services. A brief overview of these variables vividly demonstrates the fragmentation. (See Table 1)

1. Industry Growth

Between 1966 and the end of 1984, home health care agencies certified by Medicare increased in number from 1,275 to 5,237, with a 50% increase just since 1982.[18] The expansion is in response to the rapid growth in the number of people who need home health care and has been stimulated by availability of payment under Medicare. Many home care agencies are not Medicare certified, but there exists no reliable data source enumerating the total number of both certified and non-certified agencies. The number of agencies providing home health services has grown from an estimated 208 in 1961 to 1,700 in 1974[19] to an estimated 8,000 or more in 1985.[20]

The history of what we now refer

TABLE 1

Home Care - The Fragmented Marketplace

PROVIDERS	DELIVERY MECHANISMS	PAYMENT
o Private Home Health Agencies - Proprietary - Non-profit	o Direct Services o Agency subcontracting	o Medicare o Medicaid
o Public Agencies	o Independent contractors	o Title XX (Soc. Svc. Block Grants)
o Hospital-based Agencies - Proprietary - Non-profit	o Subsidiaries o Joint ventures	o Older Americans Act o State/local appropriations
o Specialty Service Agencies (e.g., Hi-Tech, Social Service, Case Management) - Proprietary - Non-profit	o Referral arrangements o HMO's/other capitated systems	o Private insurance o Out of pocket o Combination of the above
o Individuals		

to as the home care "industry" is concisely summarized by A.R. Somers:

> The contemporary home health agency is a fascinating hybrid with roots going back to various origins. Most important perhaps is the legacy of public health nursing which emerged in the mid-1800s. Hospital-based programs can be traced back to 1796, when the Boston Dispensary established a home care program primarily as a way to train resident physicians. However, a century and a half passed before the next major hospital-based experiments, this time by Montefiore and St. Vincent's hospitals in New York City. Even then, there was little emulation until the current hospital financial crunch made all types of outpatient care appear more attractive. For several decades, home nursing care was offered by life insurance companies. The comprehensive home care model, developed in Britain after World War II under the National Health Service, attracted and influenced some American planners, geriatricians, and gerontologists. Beginning in the 1950s, home nursing agencies began to augment their services with home health aides/homemakers, a new and still controversial paraprofessional category at least partially legitimized by Medicare and Medicaid.[21]

In the last few years, the remarkable feature of the home care industry is that it has been growing in two contrasting directions. On the one hand new technologically oriented specialty

services that could not have been provided in the home (nor in some cases even in the hospital) ten years ago are appearing daily in the home setting. Examples include home dialysis, IV chemotherapy, care of ventilator dependent patients, total parenteral nutrition (TPN) and special monitoring. The continual sophistication of technology will enable more bodily systems to be replaced or supplemented by hi-tech machinery in the home. At the other end of the skill continuum, the demand for the unskilled or semi-skilled services of homemakers, personal care attendants and other supportive personnel, has grown dramatically--in large part due to the recognition that the key factor in keeping an older client out of an institution is often the availability of someone who can assist with cooking, bathing, dressing and other simple daily activities. As the market expands, other less medically oriented supportive services are appearing, such as financial management services and even pet care services.

Efforts to reduce overall government health program costs, which are dominated by institutional costs, have clearly led to the promotion of home care as an alternative to more expensive nursing home care and, more recently, to hospital care. Legislative changes in the early 1980's in Medicare and Medicaid encouraged growth in the home care industry, even though administrative restrictions on coverage of services have remained very limiting. The Omnibus Reconciliation Act of 1980 (P.L. 96-499) eased certain payment restrictions for home health care under Medicare. It also eased restrictions for certification, particularly for proprietary agencies.

Proprietary agencies in states without licensure laws became eligible for the first time to apply for Medicare certification, and proprietary agencies were also allowed for the first time to arrange for outside services from other agencies. In addition, section 2176 of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) initiated the Medicaid Home and Community-Based Waiver Program that gave states limited discretion in providing home and community-based services, instead of institutional care, for Medicaid beneficiaries who otherwise would require institutional care.

Finally, the prospective payment system for Medicare hospital care begun in 1982 by the Tax Equity and Fiscal Responsibility Act (TEFRA) (P.L. 97-248) will also profoundly affect the home care industry. Initial experience with PPS indicates that patients are being discharged "sicker and quicker" from hospitals. Many of these people, who previously would have stayed longer in the hospital or gone to a nursing home, will now rely upon home health care for services.[22]

2. Varying Home Care Definitions

Home care can be most broadly defined as an array of therapeutic and preventive services provided to persons, usually in their homes, because of acute or chronic illness or disability.[23] Such a definition is too general and vague for regulatory purposes. The specific services and qualifications of providers of these services need to be defined. Unfortunately, such definitions vary and overlap considerably from state to state. This is not as great a problem

for the skilled services of doctors, nurses, social workers and physical therapists, as it is for the less skilled services of persons variously called homemakers, home health aides, attendants, personal care providers, practical nurses, chore persons, companions, or in-home supportive service workers, among others. These latter caretakers provide the range of basic social and personal services that constitute the foundation for continued residence in the home -- meal preparation, simple housekeeping, toileting and washing, emotional support. The various titles used to designate this caretaker again often reflect funding sources rather than actual tasks.

Furthermore, service and provider definitions are frequently tautological, with the service being defined in terms of the provider and vice versa. Without a greater consensus of service/provider definitions, consistent and effective regulation on a nationally recognized basis will be difficult.

3. The Confusing Mixture of Organizational Forms

The task of regulating home care is complicated by the diversity of organizational forms through which home care is provided. First, there exist the private, non-profit agencies, and Visiting Nurse Associations which formed the original core of home health care. Second, there are the proprietary organizations, particularly chains, which have emerged as the largest single form of home health organization.[24/] Third, public social service agencies may employ home care workers to provide services, or

subcontract with other agencies, or pay home care workers as "independent contractors."25/ Using independent contractors is usually more economical for social service agencies but raises the gravest problems for clients and workers with respect to quality control. Fourth, there are newer, rapidly evolving delivery forms, such as hospital-based home care programs and hospice care programs. In 1984, 42 percent of the nation's hospitals offered home health services and that fraction was expected to reach 65 percent in 1985.26/ The hospital-based providers are indicative of a current trend towards vertical integration of health services. New combinations of delivery forms are appearing as different providers team up under Health Maintenance Organizations, joint ventures, referral arrangements, subsidiary spin-offs, or contractual arrangements for specific services. Finally, there are services simply purchased by one individual from another, in which home care workers may be without any affiliation whatsoever, or may hold themselves out for hire through nurse registries, health care manpower brokers or other referral mediums. Such groups provide little screening and no supervision of care provided.

Regardless of the identity of any particular provider, the overall delivery system is characterized by a basic dichotomy between the medically oriented home care system and the social support service oriented home care system. The medically oriented "home health" system is characterized primarily by the private Medicare certified home health agencies. The social support sys- tem, which could be termed "home help," is characterized

primarily by a variety of programs, legislatively created and regulated by the states, usually under their state social service department, health department, or office on aging. The social services under these programs, tend to be more flexible in nature, including, for example, homemaker assistance, home health aides, personal care, chore persons, or community services such as adult day care. Case assessment and management are increasingly becoming key components. A means test for income or assets is usually imposed in these programs either for purposes of determining eligibility or for determining a sliding-fee co-payment.

Of the many possible examples of such programs, two include the California In-Home Supportive Services program, and the New York City home care programs. The California program provides attendant care to nearly 100,000 functionally impaired individuals in their homes. It is operated through the State's Department of Social Services utilizing federal Social Services Block Grant funds, state appropriations and some county money. Most of the attendants are relatively untrained individuals hired as "independent contractors" by the care recipient.27/

New York City, through its Human Resources Administration, operates three distinct home care programs: the home attendant program, housekeeper program, and homemaker program. The first two are financed through Medicaid; the homemaker program is financed largely with Social Services Block Grant funds. In the first half of 1982 over 33,000 people received services from these three programs.28/

4. Funding Fragmentation

While public funding for home care remains minimal compared to expenditures for acute care and nursing home care, public funding has nevertheless played the key role in shaping home care services. There are several funding sources which, because of their separate target populations, eligibility requirements, and separate administration, have tended to increase the fragmentation of home care services.

Medicare. The foremost federal funding source of home care is Medicare. Under the Medicare home-health benefit, the following types of services are covered:

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;
- Physical, occupational or speech therapy;
- Medical social services which contribute significantly to the treatment of a patient's health condition;
- Part-time or intermittent services from a home-health aide; and
- Medical supplies (other than drugs and biologicals) and medical appliances.[29]

The Medicare law limits payment for home-health services to those beneficiaries whose conditions are of such severity that the individuals are under the care of a physician, confined to their homes (homebound), and in need of part-time skilled-nursing care or physical or speech therapy on an in-

termittent basis.30/ The Health Care Financing Administration, which administers the Medicare program at the federal level, has traditionally interpreted these eligibility requirements in a very restrictive manner.

Home health expenditures constitute only about 3 percent of overall Medicare costs, yet they have been growing rapidly. From 1974-80 Medicare expenditures for home health increased at an annual rate of 34 percent. Since 1980, expenditures doubled from $772 million in 1980 to $1.5 billion in 1983.31/ This growth may slow under the federal cost cutting initiatives of the mid-1980's, but it will clearly continue to be significant. Indeed, considerable attention is now focused on possible statutory expansion of Medicare home care benefits. This fact intensifies the need to address quality concerns now.

Medicaid. The Medicaid program is a combined federal/state funding source for health care to low-income persons. It provides limited coverage for home health services. Within limits, the states have considerable discretion over coverage and eligibility groups.33/ Medicaid payments for home health services grew from just $70.3 million in 1975 to $496 million in 1982 to an estimated $596 million in 1983. This is less than 2% of all Medicaid expenditures.33/ Moreover, about three-quarters of Medicaid home health expenditures are for personal care services and three-quarters of all personal care expenditures are made in New York.34/

Section 2176 Medicaid waivers, established under the Omnibus Reconciliation Act of 1981 have provided states with a much welcomed but limited opportunity to use Medicaid funds to pay for non-institutional long-term care services of a non-medical nature (e.g., case management, homemaker/chore services, adult day care). Services must be targeted to persons who would otherwise require Medicaid-financed nursing home care, and the average per capita costs with the waiver must not exceed average per capita costs without the waiver.[35] As of July 1986, HCFA had received a total of 234 waiver requests from 48 states, of which 142 (from 47 states) had been approved. At present, 44 states are operating under 104 waivers. Many of these waivers cover relatively small numbers of eligible persons in selected areas of the states. Others are statewide with the most common waivered service being case management.[36]

Social Services Block Grants. Title XX of the Social Security Act (1974) provides federal block grants to states for a wide range of social services to persons of all ages eligible under state-established standards. Services that may be available to the elderly include homemaker, home health aide, personal care, day care, and senior centers. Institutional care is excluded.[37] In 1980 total Title XX expenditures for community-based long-term care were estimated at $809 million by the federal government plus $420 million by the states.[38]

Older Americans Act. The Older Americans Act of 1965 (P.L. 89-73) and

its subsequent amendments provide funding, channeled through state and local agencies on aging, for a wide and flexible range of community services for persons over age 60.[39] Services typically range from health services and home care to nutrition programs, legal services, transportation and even home repair. The Older Americans Act provided approximately $724 million in fiscal 1980 for all community-based services to the elderly.[40] Most of this was for nutrition programs. Home-based expenditures under the Act are not separately reported.

Other Sources. In addition to the above, other federal entities such the Veterans Administration and the military branches provide or spend funds for home care services. States may also appropriate additional general revenues or designate special funds for home care. Pennsylvania, for example, designates certain funds from the state lottery for services to the elderly.

Private long-term care insurance has gained considerable attention lately as a potential resource for funding home care. To date, private insurance has paid less than 1% of the cost of all nursing home and home care combined. Nevertheless, this means of financing is expected to grow substantially in the coming years.[41]

Finally, out-of-pocket expenditures for home care are undoubtedly substantial, even though precise data are unavailable. Estimates for 1982 indicate that the disabled elderly population spent $1 billion out of pocket that year for home based care, plus an additional $850 million to $1 billion for durable

medical equipment and supplies.42/

Chapter III

THE ELUSIVE CONCEPT OF QUALITY

What is Quality?

The concept of quality, even when economic considerations are put aside, is elusive. Quality has many dimensions which may vary with the viewpoint of the examiner.[43] Besides economic interpretations, there are physical, psychological, functional and social interpretations of quality. Most people will agree that high quality of care in basic terms means meeting the individual's medical, emotional, psychosocial, and rehabilitative needs and effectively encouraging his or her maximum functional independence. However, translating this ideal into operational standards is where the real difficulties begin.

A complete regulatory system contains not only appropriate quality standards but also two other components: a monitoring system and enforcement system. Even with all three components firmly in place, the system itself does not create quality. Ultimately, that can only come from the people and organizations that provide the care. The regulatory system at best provides only some crude measures of quality and a system of checks and balances to identify and stop clearly substandard or abusive services. Thus, regulation functions more as a negative prophylactic than as a positive insurance.

Compared to other components in the continuum of care, home care has an additional, unique problem with respect to regulation. Maintaining a person in his

or her home does not just mean maintaining that person's health and functional ability in an objectively defined way; it also means maintaining his or her personal lifestyle to a far greater extent than is possible in any residential long-term care setting. Home care is the one health care setting where the provider comes into the patient/client's domain rather than vice versa.

The quality of life is really a dimension separate from quality of care, yet fundamental to a patient's well-being and to the whole philosophy of in-home care. Quality of life is also idiosyncratic to the patient/client in a way that conflicts with the notion of uniformity of standards and procedures.

It is noteworthy that the quality of life concept has also emerged as a key concern in the field of nursing home regulation reform. The Institute of Medicine, in its recent seminal report on improving the quality of care in nursing homes, recommends that quality of life, in addition to quality of care, be incorporated as a condition of participation in the Medicare program.44/

To achieve quality of life objectives theoretically means finding criteria unique to each client. It is highly unlikely that a regulatory system could directly ensure this kind of process. Nevertheless, there may be ways that a regulatory system can orient itself sufficiently toward a goal of accountability to the individual client so as to make this process possible. This orientation toward client ac- countability will be discussed in more detail below.

Quality in Terms of Structure, Process and Outcome

Theorists have generally recognized three basic traditional categories of quality of care standards in health care: structural, process and outcome measures.[45] Structural standards focus upon the organization and framework for care, setting requirements for organizational form, facilities and equipment, fiscal resources and management, number and qualifications of staff, and other such indices. Structural standards tend to measure an entity's capacity to deliver services rather than the quality of the actual services rendered.

Process standards focus on the actual procedures followed in delivering care and compare them to accepted norms for what good care should look like. Such standards for performance would, for example, require surveyors to examine a sample of cases to determine what happened during the care and treatment of that patient: Was an assessment done in accordance with prescribed requirements? Was an appropriate care plan devised and followed? Were the staff supervised as required? And so on.

Outcome measures are concerned with the end result of care: whether there is any measurable change (or stabilization) in the health or social status of the patient as a result of services rendered. Outcome measures are obviously easier to develop where there are discrete, changeable physical conditions being examined, as is common in hospitals or other acute care settings. Outcome measurements for chronic conditions and

mental or physical functional limitations are harder to come by, although still conceptually feasible.

Each of these three categories of standards possess inherent strengths and weaknesses which make them helpful but by no means complete measures of quality. Structural measures have been the primary component of the Medicare Conditions of Participation for home health agencies and more so for skilled nursing facilities. Advocates for nursing home residents have even chailenged the nursing home survey process, in part, for this reason, pointing out that some 541 items on the federal inspection form fewer than 30 were even marginally related to patient care or required any patient observation.46/ It is not difficult to see why structural mechanisms have been so favored in the regulatory process -- they can be surveyed primarily by a review of paper and perhaps an interview with an administrator. This is the easiest kind of function for a monitoring agency to perform. And, it has been justified on the assumption that if the provider of care has the capacity to provide good care, in all likelihood it will provide good care. Unfortunately, the assumption is not always borne out by experience.

Process standards have the advantage of examining actual care given, yet they are still limited in fundamental ways. Since every procedure and activity is expected to be documented in some way, this form of quality assessment also tends to rely heavily on paper review. Moreover, performance measures need to define the technically correct steps and decisions a provider must make. In long

term care, as contrasted to acute care, process standards are difficult to validate. The client's medical problems are typically chronic and multiple, and the client's social/personal/lifestyle needs (i.e., quality of life) are of greater importance than in acute care settings.

Outcome measures may be the most rationally sound form of measure; but the further one moves from examining purely medical outcomes, the more difficult it is to develop valid measures of outcome. Even where validated outcomes are measureable, the failure to achieve the desired outcome is not enough on which to base any conclusion about quality. One would still need to look at the whole process of care to see whether there were any legitimate reasons why the outcome was not achieved. Outcome-oriented quality assurance audits have been attempted by both the Colorado and Florida Association of Home Health Agencies and by the Public Health Nursing Section of the Minnesota Department of Health. They follow a traditional medical model by organizing patient care review around specific medical diagnoses with the assessment based on a comprehensive range of identifiable outcomes.

Both process and outcome standards have the additional problem of being time consuming, and therefore, expensive to develop, and even more so to carry out. Regulating bodies may have neither the requisite skills, manpower or funds to carry out effective surveying and monitoring schemes. All three approaches primarily depend for their implementation upon the functioning of some kind of well-trained, third-party watchdog. The watchdog may be a state health dep-

artment, the state licensing agency, an accrediting body, professional review organization, or the federal government itself.

Focusing on Accountability to the Consumer

The home care consumer, who is by definition physically or mentally dependent to some degree, is heavily dependent upon the regulatory system at all stages of the regulatory process: at the standard-setting stage (deciding what good care is), at the monitoring stage (evaluating the care given), and at the enforcement stage (taking corrective action when care is poor). While this dependency is inherent in the consumer protection underpinnings of the regulatory system, it also points out the lack of attention given to ways to directly empower the consumer within the regulatory framework. The traditional regulatory response has been to empower, sometimes quite unsuccessfully, a regulating agency. The care provider becomes accountable to some form of bureaucracy and not necessarily to the consumer.

Accountability to the consumer plays a potentially central role in any model of checks and balances for quality assurance in home care. It should be a fundamental value and goal in home care regulation, not because it is a substitute for structural, process or outcome mechanisms, but because it has been a largely de-emphasized strategy and neglected value. It is a goal that acknowledges that quality in home care is uniquely client-specific and therefore should be controlled by the patient/client to the maximum extent feas-

ible. To the extent that the goal of accountability to the consumer can be translated into a regulatory scheme, it holds the potential of increasing quality monitoring and enforcement without necessarily increasing regulatory bureaucracy.

CHAPTER IV

THE INADEQUACY OF THE CURRENT SYSTEM

The Problems

Several inadequacies are inherent in existing regulatory approaches to home care quality:

1. Lack of Data

Most fundamental to policy decisionmaking is reliable information and data. Home care nationwide is presently a "black box" the workings of which are largely a mystery. The industry enjoys a generally high level of regard by the general public. However, quality problems are not at all uncommon, ranging from failures of workers to appear on time and sitting down on the job to theft, fraud, abuse and exploitation.[47] We view quality of care problems in home care today only anecdotally, for there is no adequate data collection system to track such problems, neither under Medicare nor under most state regulatory programs nor within the industry itself. The number of providers is not even known with any reliability.

In nursing home care, state ombudsman programs in all 50 states have established themselves as patient oriented responders and resolvers of problems concerning patient care. At the same time, they have become an additional resource for identifying and quantifying quality of care problems in nursing homes. Most states limit the ombudsman's oversight to institutional care.

2. Capacity vs. Actual Care

The existing standards focus far more on measuring an agency's capacity to deliver good care rather than on the actual care given. Structural standards tend to make up the core content of these systems. Twenty years of regulatory history in the nursing home industry has shown that having the capacity to provide good care, while a necessary condition, is by no means a sufficient condition to ensure good care. The same reality undoubtedly holds true for home care.

3. Consumer Accountability

A third problem can be described as a lack of direct accountability to the consumer. With some exceptions, existing regulation provides little in the way of:

- explicit consumer rights and choices;
- disclosure requirements;
- consumer input in program evaluation;
- easily usable grievance mechanisms with the power to effect remedies and/or sanctions;
- a formal voice in overall regulatory policy.

Moreover, home care consumers are by definition sick, frail or impaired. They may not be in a position where they can speak up or exercise their rights very capably or perhaps at all. Yet, most systems offer no advocate or entity charged with representing consumer interests and having the standing or authority to advance consumer interests or seek sanctions within the system.

4. Monitoring and Evaluation

The typical monitoring and evaluation components of existing systems are weak. Monitoring entities such as health departments, licensure agencies, or accrediting bodies presently lack the resources, authority, or expertise to perform ongoing monitoring of care. Mandated self evaluations, while a useful function, can all too often be complied with by filling out the papers and going through the motions, thereby avoiding the real purpose of the process.

Other models for monitoring are available but not widely used. For example, professional review organizations (PROs) mandated for Medicare hospital review have no counterpart in home care. Officially sanctioned consumer advocates or ombudsman type programs are rare in home care. Experimentation with case management systems is widespread, but the current focus on case management centers largely on its potential to control costs. It may also offer tremendous potential as a tool for quality assurance and monitoring.

5. Sanctions

Existing systems contain few sanctions for inadequate care and very little, if any, reward for outstanding care. The most enlightened standards and the best trained and staffed monitoring team will fall short in effectiveness unless there are strong and flexible sanctions and incentives available to both the state and consumers to enforce the whole system.

What Quality Control Systems Are Now In Place?

1. Federal Standards

The predominant approach to regulation of home care at the federal level is Medicare certification. It is a voluntary process for home care agencies but necessary in order to receive reimbursement for both Medicare and Medicaid covered services. The federal standards are referred to as the Medicare "Conditions of Participation."

The Older Americans Act and the Title XX Social Services Block Grant programs are essentially the sole federal sources for funding non-medical home based care. Neither impose any standards for in-home care.

2. State Standards (See Appendix)

At the state level the most common regulatory mechanism is licensure. Other potential sources of regulation are the various state and local sources of funds: state Title XX annual service plans; legislatively created standards for state funded home care programs; Medicaid section 2176 state waiver program standards for providers; state Office on Aging regulations; and area agencies on aging which may set standards under local grants or sub-contracts.

These various reimbursement-related state sources of regulation vary tremendously from state to state or are non-existent altogether in some states. None achieves the goal of a comprehensive and consistentapproach to quality assurance regulation for all home

care services. Instead, their single program scope of authority contributes to the fragmentation and con- fusion in the industry.

3. Industry Accreditation

The primary industry approach to self regulation is accreditation. It is a process by which an independent private entity develops standards for agencies and institutions and establishes a process for evaluating, approving and monitoring the agency against the standards. The majority of home care providers, particularly the proprietaries, have not sought accreditation, in large part because it is an additional cost to the agency and there is little incentive to undertake the effort. It is generally not required by funding sources, laws, or regulations; and the public is not aware enough of the home care industry to demand it. Nevertheless, the accrediting programs available provide instructive models for this inquiry. Three major accrediting bodies deserve mention:

o The Joint Commission on Accreditation of Hospitals (JCAH) accredits home care programs which are affiliated with hospitals. JCAH also accredits hospice programs which are part of home care programs whether or not they are hospital-based. JCAH is currently developing an accreditation program for free standing home health care facilities. The expected implementation date is 1988.

As of 1986, the JCAH has accredited about 1000 hospital-based programs.[48/] The number has been growing because of the tremendous growth

of hospital-based programs. Just between 1984 and 1985 the estimated proportion of hospitals offering home health services increased from 42 percent to 65 percent.[49] The JCAH has exercised significant clout in the national regulation of hospitals, primarily because in 1965 the federal Medicare and Medicaid law granted hospitals accredited by the JCAH "deemed status," a proxy for Medicare certification which allowed them to participate in these federal programs.

o The National League for Nursing (NLN), now in conjunction with the American Public Health Association (APHA), has operated an accrediting program for home health agencies and community nursing services since 1961. The program accredits approximately 100 agencies.[50]

o The National Home Caring Council (NHCC), formerly the National Council for Homemaker-Home Health Aide Services, has accredited homemaker/home health aide programs since 1972. About 140 entities are accredited by NHCC.[51] As of 1986, NHCC is planning to merge with another home care organization. Therefore, the future of the accreditation program is uncertain.

4. Long-Term Care Ombudsman

The Older Americans Act of 1985, as amended, requires each state to operate a long-term care ombudsman program to investigate and work to resolve complaints made by or on behalf of older residents of long-term care facilities and to monitor the development and implementation of federal, state and local laws with respect to long-term care

in the state. The ombudsman programs also are required to provide information to public agencies regarding the problems of older people in long-term care facilities and to train volunteers and promote the development of citizen organizations to participate in the ombudsman program.

In most states, the ombudsman program has become a well established fixture for addressing problems in residential long-term care facilities. However, the ombudsman's authority normally does not extend to home care services. Only a very few states, such as Maine, Virginia and Wisconsin, have extended the scope of the ombudsman program to cover in-home care. The ombudsman model functions primarily as a responder to problems of consumers, rather than as an ongoing monitor. It also performs an ancillary function of collecting data about the nature and extent of problems. In the field of home care, the potential of the ombudsman program or similar model to perform these functions remains largely untapped.

5. Certificate of Need

One other player in the present regulatory collage is the Certificate of Need (CON) mechanism, which exercises some control over quality through a gatekeeping function. The CON process was created in 1974 by the National Health Planning and Resources Development Act (P.L. 93-641). The law requires centralized state health planning agencies to control the development of health facilities and services on the basis of a predetermined standard of need. By controlling entry into the field, the

system aims to positively in- fluence quantity, cost, and quality of care.

The law does not require states to apply the CON mechanism to home health care services, but about 30 states include some component of the home health sector under their CON system.[52] Although noteworthy for its planning and gatekeeping functions, the CON mechanism exercises minimal influence over the ongoing quality of home care services.

6. Other Legal Controls

Transcending the formal regulatory framework are other legal and economic realities that undoubtedly influence the nature and quality of home care in selective ways. The protective backstop of the law that presumably deters or punishes the worst abuses is the criminal law system. Neglect and abuse, are not rampant in the home care field, but neither are they unknown.[53]

Tort law has an impact on quality standards by giving some definition and recognition to generally accepted standards in the context of individual claims of injury. It also defines the "locus" of responsibility when things go wrong. This could potentially have a significant impact on home care because responsibility is so diffuse among many different actors in the system: program administrators, doctors, nurses and other professional staff, supervisors, aides, case managers, discharge planners, subcontractors, and the agencies themselves.

The insurance industry, besides setting the cost for liability coverage, is finally giving serious consideration

to more comprehensive forms of long-term care insurance, including the coverage of home care.54/ As a potential payor for home care, the insurance industry could play a significant role in defining the nature and quality of home care services.

Employment and labor law indirectly regulate home care by recognizing various rights of employees and responsibilities of employers, including collective bargaining and the establishment of employee benefit plans. Because the unskilled and semi-skilled home care worker today is largely a part-time, minimum wage earner with few if any benefits, this area of law may play an important role in legitimizing and raising the career status of this component of the work force.55/

Finally, even federal and state tax laws indirectly regulate home care by the kinds of tax breaks or liabilities they establish for proprietary and nonprofit providers, and by the kind of incentives that they may create for families to contribute to the long-term care needs of older members.

What Do Current Standards Cover

Medicare certification requirements, the various accreditation standards, and the several state regulatory laws each organize and describe their home care standards in different ways. A general comparison of formats illustrates the point.

- The Medicare conditions of participation for home health agencies contain 11 conditions further broken down into a total of 23

standards.

- o The Joint Commission on Accreditation of Hospitals home care standards for hospital based programs set forth 5 standards, each followed by narrative interpretations.
- o The National Home Caring Council's national accreditation standards are comprised of 11 standards, divided among four general areas: structure, staffing, service, and community.
- o The National League for Nursing accreditation criteria contain 28 criteria, divided among six general areas: community assessment, organization and administration, program, staff, evaluation, and future plans. Each of the 28 criteria is further elaborated by more specific standards and a brief description of the evidence needed to show compliance with each standard.
- o The substantive portions of the New York State licensure regulations are divided into two main parts: Organization and Administration (covering governing authority, contracts, personnel, records and reports, and emergency preparedness) and Patient Services (covering patient rights, policies and procedures, plan of care, physician orders, supervision, and patient care records).56/

Regardless of their organization or phraseology, these various regulatory approaches inevitably cover four basic topics:

1) Structure/Organization: This topic includes rules for organizational structure, governance, administration, and fiscal accountability, and typically

a mandate to comply with all applicable laws. It may also include rules for subsidiary/parent company arrangements, company ownership disclosure, subcontracting arrangements and inter-agency agreements.

2) Personnel: This area generally covers staff qualifications, required staffing, education and training, evaluation, supervision, and written personnel policy requirements.

3) Service Delivery: This topic is comprised of requirements affecting actual service delivery, including requirements for admission and discharge, patient assessment, care plans, and review of care plans. Documentation and clinical record requirements are included under this topic, although it is an important enough topic that some would consider it a separate major topic. The Medicare conditions of participation, for example, treat clinical records as a separate condition, and the JCAH standards treat documentation requirements for all administrative and professional activities as a separate standard.

4) Evaluation: What must be evaluated, by whom, when, and with what consequences are the questions answered by this regulatory topic. The topic may include overall program evaluation by insiders, outsiders or both; clinical record review; utilization review; patient/client satisfaction or community input; program data reporting requirements; and possibly as assessment of community needs.

Chapter V

OPTIONS FOR ASSURING QUALITY CARE IN THE HOME

The Challenge

The shortcomings of existing quality assurance systems are formidable but not insurmountable. On the state level, licensure systems deserve a total rethinking, for their potential has been largely underused. Licensure has the unique potential of being made applicable across all service types and all funding sources if states were to choose to do so. This could significantly reduce the fragmentation that plagues the field.

On the federal level, the limited Medicare definition of home health services no longer serves as a useful benchmark for home care. It is out of step with the changing marketplace which has recognized a broader, evolving range of needs and services essential to maintain people at their maximum potential in the community. A potential federal role exists for bridging the fragmentation in definitions, standards, monitoring and enforcement; and for enhancing their effectiveness. Federal funds already either directly or indirectly touch a large portion of home care services in the country. The receipt of these funds, through whatever source, could be made contingent upon compliance with a uniform statewide or even nationwide quality assurance program applicable to the full range of home care services.

Underlying Tensions

Whether at the state or federal

level, policymakers will need to recognize and resolve up front some basic underlying tensions inherent in quality assurance regulation.

Burden vs. Impact. The most basic tension arises from the very real concern that many well-intentioned regulations may create a far greater administrative burden than the benefit they will have on quality. If the administrative burden has a real payoff in terms of quality and accountability, then it may be well worth the effort and expense. If it does not, then it may do little more than divert an agency's resources from the delivery of care to the management of paper. Unfortunately, the burden vs. impact equation is not a very easy one to calculate, and the key players in the system will frequently disagree in their conclusions.

Consumer power. A second underlying tension involves the ambivalence of both providers and policy-makers over any system that really empowers consumers. The importance of consumer satisfaction and consumer control in the regulatory scheme, is acknowledged only superficially. In practice, it tends to be significantly undervalued and criticized as too unrealistic (i.e., patients are too incapable) and too subjective (i.e., based more on emotional responses to personalities rather than on care quality). Since a major regulatory option recommended in this report is the enhancement of consumer accountability and control, this ambivalence will arise as a recurring obstacle.

Minimum vs. Maximum. A third underlying tension arises from differing

views over whether public regulation ought to define the absolute minimum acceptable standards for agency operation or, instead, normative standards of practice. The former define the bare minimum; the latter the industry standard or norm. Traditionally, the task of regulation has been to set minimums, below which an organization is prohibited from doing business. However, in a market such as home care where the consumer does not wield a great deal of power, the minimum often becomes the maximum. Therefore, a strong argument can be made for higher minimum standards. Whatever written standards are finally adopted will probably reflect some kind of compromise between these two views.

Apples vs. Oranges. A fourth underlying tension involves the accommodation of the varied and changing array of providers and services in a single regulatory scheme: large multi-service providers vs. small single service providers; new hi-tech services vs. companion and chore services; private sector vs. public sector providers; proprietary vs. non-profit; and heavily staffed agencies vs. those dependent on volunteers. Which of these characteristics merit accommodation or exemption from regulatory requirements? When is one lumping apples and oranges together? Obviously, there are no universal answers; but the answers will determine how universal the regulatory controls will be.

RECOMMENDATIONS

1. Wider applicability of standards

Existing standards for licensure, certification, accreditation and other forms of quality assurance apply to differing slices of the home care field. A large portion of home care services need meet no standards whatsoever. A fundamental policy goal should be to establish as nearly universal a system of standards and quality control as possible -- one that cuts across agency types and funding sources. On the state level, an option would be to establish or extend a licensure system to all home care services intended to maintain sick or functionally impaired persons in their homes. Presently, most state licensure is limited to traditionally medically oriented home health agencies. On the federal level, an option would be to strengthen what are now called the Medicare Conditions of Participation and to expand their applicability to any home care service or agency receiving federal funds. This would, at a minimum, encompass programs funded wholly or in part by Medicare, Medicaid, Social Services Block Grants and the Older Americans Act.

2. Strengthening the content of standards

Current examples of home care standards focus heavily on agency structure, policy, and procedure -- characteristics which pertain more to the capacity of the agency to provide good care than to the actual care given. Compliance often depends more on completing paperwork correctly than on performing the actual care with quality.

Improved and strengthened standards are needed, which not only measure basic structural and procedural characteristics but also focus on patient-worker interactions and quantifiable outcomes of care.

3. Bonding and insurance

In order to provide a base-line of protection for consumers for loss or injury caused by negligence or misconduct of a home care worker, home care regulations should mandate minimum bonding and liability insurance requirements.

4. Consumer empowerment

The home care regulatory system should recognize accountability to the consumer as a fundamental goal. Consumer empowerment strategies require an examination of at least five elements:

o Patient/Client rights. These should articulate in some detail basic individual rights and liberties (e.g., rights to courtesy and respect, privacy, confidentiality, security, freedom from abuse, non-discrimination) and specific care protocols (e.g., involvement in creating and evaluating a written care plan, the right to refuse treatment or services, the right to have properly trained staff, and coordination of all services).

o Disclosure requirements. Disclosure protocols are aimed essentially at educating patient/clients so that they have the information and knowledge they need to make decisions and act in their best interest. Disclosure protocols in- clude matters such as a description of agency

services; information about al- ternative services available in the com- munity; costs and billing statements, regardless of source of payment; worker's and supervisor's name and number; advance notice of changes in services; patient/client rights; and grievance procedures.

o Grievance mechanisms. Effective grievance mechanisms are essential and should be formulated with the characteristics of the consumer foremost in mind. Sickness, impaired ability, and significant dependency on one's caretakers all create enormous disincentives against voicing criticism or pursuing complaints. To remedy this imbalance, supports and incentives should be built into the system to facilitate and, in some respects, encourage its use by clients. Procedures need to be easily understandable and simple to trigger.

One possible strategy would be to require regular surveys of clients to elicit comments and complaints. This function could be performed by a supervisor, or more preferably, by a nonemployee of the agency, such as an outside case manager or client advocate.

To enable clients to pursue remedies once problems are uncovered, policy-makers should consider building into the system a patient/client advocacy resource that has the standing and authority to seek remedies and sanctions. A state ombudsman program or publicly funded patient advocate could provide the vehicle for such a function.

Finally, grievances and their documented outcomes need to be tied dir-

ectly into the monitoring/evaluation function of the regulatory system, so that they become one of the determinants of the agency's licensure or certification status.

o Consumer input in program evaluation. The Medicare regulations and most state licensure schemes require some form of annual program evaluation to be performed by home care agencies. Medicare and several states require some consumer involvement in the process but do not define that involvement in any way. Consumer input in the evaluation process should be expressly incorporated into program evaluation in two ways. First, consumer involvement on the evaluating team should be specifically defined in terms of selection, authority, and number or proportion. Second, the data collected for review should include a defined representative sampling of clients who are solicited for their assessment of the care received. Both active and closed cases should be included, and family members should be surveyed where the patient/client is unavailable or unable to respond.

o Consumer policy voice. Advisory bodies to individual agencies and to regulating entities should include defined levels of consumer participation. These bodies provide direction and advice on matters of standard setting, policy, program operation and monitoring. To foster consumer participation, more than just an invitation is necessary, for participation may be impeded by physical handicaps or lack of resources. Therefore, the system may need to provide for transportation, interpreters, personal care attendants, or other resources.

necessary to enable consumers to participate in advisory group functions.

5. Monitoring

The quality assurance monitoring function of the regulatory system should have both a periodic component (usually annual inspections) and a responsive component (triggered by a complaint or other evidence of quality problems). The monitoring process itself should expand its focus beyond the traditional structure, policy, and document review to include client-centered review, wherein monitors directly survey both clients and workers. An instructive model for this may be found in the Institute of Medicine's recommendations for improving quality of care in nursing homes.[57]

Since one of the recommendations of this report is the establishment of a quality assurance system that cuts across all agency types and funding sources, a new form of monitoring entity should be considered. A possible model is the use of an interdisciplinary, independent entity, having the necessary expertise available to evaluate both the professional and non-professional, medical and non-medical services included under home care.

With respect to its responsive component, the monitoring system should be complemented by an ombudsman type consumer-oriented entity. This may be accomplished by expanding the jurisdiction and resources of existing nursing home ombudsman programs to include home care, or creating a patient advocate program specific to home care.

6. Sanctions

The range of formal sanctions available to enforce quality of care problems is most commonly limited to denial, revocation or suspension of an agency's status, whether it be licensure, certification or accreditation. A strong system of accountability requires a flexible range of administrative and judicial enforcement sanctions. Additional administrative sanctions should include the ability to impose restricted or provisional licenses, pending correction of deficiencies and civil fines. Fines should be commensurate to the seriousness of violations and costly enough to encourage compliance. Judicial sanctions include injunctive relief to require compliance and criminal sanctions for serious violations. An additional option is a receivership sanction, under which a court may temporarily appoint a "receiver" to assume management of an agency in serious trouble in cases where continuation of client care is essential.

While not a sanction in a formal sense, the public disclosure and dissemination of information about agencies out of compliance with required standards is recommended as a way of enhancing the impact of the formal sanction. It is a tool aimed at increasing consumers' market power through information about provider quality.

Finally, the system of sanctions should grant recipients of home care a "private right of action" enabling consumers, and advocates for consumers or groups representing consumers to sue providers that do not meet minimum required standards.

7. Education and training

Homemaker-home health aides, personal care attendants and other non-professional or paraprofessional workers who provide the bulk of day-to-day supportive services in the home are largely untrained or under-trained. At a minimum, homemaker-home health aides and personal care attendants (or functionally similar personnel) should be required to complete an established and approved course of instruction, provided through a recognized educational entity such as a community college, leading to certification or licensure of the individual. Minimum orientation and in-service training requirements for all personnel should also be mandated.

8. Research and Data Collection

Our present state of knowledge about the home care field and about quality of home care services is inadequate. Research and improved data collection on all aspects of home care are needed, especially with respect to improving the accountability of services to the consumer and public. Public regulation of home care must contain adequate flexibility and incentives to encourage research and experimentation in new forms of services and their delivery, the monitoring of these services, and, in all cases, the evaluation of the quality of these services.

REFERENCES

1/ Doty, P., Liu, K., and Wiener, J. An Overview of Long-Term Care, Health Care Financing Review, Vol. 6, Number 3, Spring 1985, p. 70.

2/ U.S. Senate Special Committee on Aging. Aging America: Trends and Projections, Washington, D.C., (1985-86 ed.) p. 89.

3/ Id. pp. 8-12.

4/ Levit, K., et al. National Health Expenditures, 1984, Health Care Financing Review, Vol. 7, Number 1, Fall 1985, p. 5.

5/ Ibid.

6/ Ibid.

7/ Liu, K., Manton, K., and Liu, B. Home Care Expenses for the Disabled Elderly, Health Care Financing Review, Vol. 7, Number 2, Winter 1985, p. 54.

8/ Doty, P., Liu, K., and Wiener, J. An Overview of Long-Term Care, Health Care Financing Review, p. 73.

9/ U.S. Senate Special Committee on Aging. Aging America, p. 73.

10/ Id. p. 12.

11/ Doty, P., Liu, K., and Wiener, J. An Overview of Long-Term Care, Health Care Financing Review, p. 70.

12/ U.S. Senate Special Committee on Aging. Aging America, p. 89.

13/ Doty, P., Liu, K., and Wiener, J. An Overview of Long-Term Care, Health Care Financing Review, p. 70. See also, Feller, B., Americans Needing Help to Function at Home, Advancedata, Number 82, September 14, 1983, National Center for Health Statistics, Washington, D.C., p. 1.

14/ Berk, M., Bernstein, A., Use of Home Health Services: Some Findings from the National Medical Care Expenditure Survey, Home Health Care Services Quarterly, Vol. 6, Number 1, Spring 1985, p. 18.

15/ Liu, K., Manton, K., and Liu, B. Home Care Expenses for the Disabled Elderly, Health Care Financing Review, p. 52. See also, U.S. Senate Special Committee on Aging. Aging America, p. 96.

16/ Layzer, E. Regulation of Homemaker Home-Health Aide Services, Levinson Policy Institute, Brandeis University, December 1977, p. 36.

17/ Id. pp. 14-23.

18/ Levit, K., et al. National Health Expenditures, 1984, Health Care Financing Review, p. 5. See also, Ryder, C. Planning for Home Health Services: A Resource Handbook, U.S. Department of Health and Human Services, Publication No. 80-14017, Washington, D.C., August 1980, p. 6.

19/ Shinn, D., and Robinson, N. Trends In Homemaker-Home Health Aide Services, Abstracts for Social Workers, Vol. 10, Number 3, Fall 1984, p. 5. The current estimate of the number of agencies is based on informal estimates provided by the National HomeCaring Council.

20/ Council of Better Business Bureaus and National HomeCaring Council. All About Home Care: A Consumer's Guide, (2nd ed.) 1983, p. 1.

21/ Somers, A., Financing Long-Term Care for the Elderly: Institutions, Incentives, Issues, in, Institute of Medicine and National Research Council. America's Aging, Washington, D.C., National Academy Press, 1985, p. 196.

22/ U.S. General Accounting Office. Letter to the Honorable John Heinz, Chairman, Special Committee on aging, United States Senate, Information Requirements for Evaluating the Impacts of Medicare Prospective Payment on Post-Hospital Long-Term-Care Services: Preliminary Report (GAO/PEMD-85-8), February 21, 1985, p. 4.

23/ U.S. Department of Health, Education and Welfare, Health Resources Administration, Health Resource Statistics: Health Manpower and Facilities, Washington, D.C., 1976-77, p. 393.

24/ Levit, K., et al. National Health Expenditures, 1984, Health Care Financing Review, p. 5.

25/ An example of a system that heavily utilizes independent contractors in the California In-Home Supportive Services Program. See, Zukas, H., Cone, K., and Leon, J. Descriptive Analysis of the In-Home Supportive Services Program in California, unpublished paper, World Institute on Disability, 1720 Oregon Street, Berkeley, CA 94703, 1985.

26/ Levit, K., et al. National Health Expenditures, 1984, Health Care Financing Review, p. 4.

27/ See, Zukas, J., Cone, K., and Leon, J., Descriptive Analysis of the In-Home Supportive Services Program in California.

28/ See, Caro, F., and Blank, A. Home Care in New York City: The System, The Providers, The Beneficiaries, unpublished paper, Community Service Society, 105 East 22 Street, New York, NY 10016, 1985.

29/ 42 U.S.C. §1395 (m); 42 C.F.R. §409.40.

30/ 42 U.S.C. §1395f(a)(2)(C); §1395x(m); 42 C.F.R. §409.42.

31/ Doty, P., Liu, K., and Wiener, J. An Overview of Long-Term Care, Health Care Financing Review, p. 73.

32/ 42 U.S.C. §§1396d(a) and 1396a(a)(10)(C); 42 C.F.R. §440.220.

33/ Doty, P., Liu, K., and Wiener, J., An Overview of Long-Term Care, Health Care Financing Review, pp. 72, 75.

34/ Id. p. 72. See also, U.S. Department of Health and Human Services, Health Care Financing Administration. Medicare and Medicaid Data Book, Washington, D.C., 1983.

35/ 42 U.S.C. §1396n; 42 C.F.R. §440.180, 441.302 (1985).

36/ U.S. Department of Health and Human Services, Health Care Financing Administration, unpublished data.

37/ 42 U.S.C. §1397 et seq.; 45 C.F.R. 96.1 et seq.

38/ Somers, A., Financing Long-Term Care for the Elderly: Institutions, Incentives, Issues, in, Institute of Medicine. America's Aging, p. 196.

39/ 42 U.S.C. §3001, et seq.; 45 C.F.R. §1321.1 et seq. (1985).

40/ Somers, A., Financing Long-Term Care for the Elderly: Institutions, Incentives, Issues, in, Institute of Medicine. America's Aging, pp. 186, 209.

41/ Sabatino, C. An Advocate's Primer on Long Term Care Insurance, BIFOCAL, Vol. 6, Number 4, Winter 1985. American Bar Association, p. 1.

42/ Liu, K., Manton, K., and Liu, B. Home Care Expenses for the Disabled Elderly, Health Care Financing Review, p. 54.

43/ Donabedian, A. Evaluating the Quality of Medical Care, Milbank Memorial Fund Quarterly, Vol. 44, 1966, pp. 166-206.

44/ Institute of Medicine. Improving the Quality of Care in Nursing Homes, Washington, D.C., National Academy Press, 1986.

45/ Layzer, E. Regulation of Homemaker Home-Health Aide Services, pp. 52-58; Donabedian, A. Evaluating the Quality of Medical Care, Milbank Memorial Fund Quarterly, pp. 168-70.

46/ Smith v. Heckler, 747 F.2d 583, 588 (10th Cir. 1984), rev'g Smith v. O'Halloran, 557 F.Supp 289 (D. Colo. 1983).

47/ Robinson, D. When the Elderly Are Victims, Parade Magazine, September 25, 1983; Banks, S., and McGran, C. An Ailing System of Health Care, Los Angeles Times, July 25, 1985, p. 1; Montgomery, J. As Health Care at Home Rises, So Do Problems, The Wall Street Journal, December 17, 1985, p. 33.

48/ Personal Communication from the Joint Commission on the Accreditation of Hospitals, July 1986.

49/ Levit, K., et al. National Health Expenditures, 1984, Health Care Financing Review, p. 4.

50/ National League for Nursing. Home Health Agencies and Community Nursing Services Accredited by NLN/APHA, NLN, Publ. No. 21-1645, New York, October 1981.

51/ National HomeCaring Council. Directory of Homemaker-Home Health Aide Services, Accredited/Approved, New York, May 1984.

52/ Collier, G. Certificate of Need Requirements for Home Health Services, Caring, May 1984, pp. 19-27.

53/ See, Robinson, D. When the Elderly Are Victims, Parade Magazine; Banks, S. and McGraw, C. An Ailing System of Health Care, Los Angeles Times; Montgomery, J., As Health Care at Home Rises, So Do Problems, Wall Street Journal.

54/ Sabatino, C. An Advocate's Primer on Long Term Care Insurance, BIFOCAL, Vol. 6, Number 4, Winter 1985, American Bar Association, p. 1.

55/ See, Fine, D., The Home as Workplace: Prejudice and Inequity in Home Health Care, unpublished paper prepared for Visiting Nurse Association of San Francisco, January 1984.

56/ 10 NYCRR §§766, 767.

57/ Institute of Medicine, Improving the Quality of Care in Nursing Homes, Washington, D.C., National Academy Press, 1986.

APPENDIX
SUMMARY OF STATE REGULATION

The primary form of state regulation over home care services is licensure. Thirty-four states (including the District of Columbia) have licensure laws as of June 1986. Ohio requires the registration of home health agencies, but that is not treated as licensure for purposes of this summary. The table on the following pages compares the basic scope of licensure coverage and other selected aspects of existing state licensure laws and regulations. The focus of comparison is primarily on requirements relating to accountability to consumers. The Medicare Conditions of Participation are included in the table for comparison purposes. Six states (DE, DC, LA, MO, PA and VA) do not have final regulations; therefore, the information in the table is based only on their statutory provisions and could be significantly altered upon final passage of regulation. The table is derived only from provisions contained in state licensure laws and regulations. Therefore, inferences cannot be drawn regarding the implementation of any provisions listed.

Explanation and Summary of Table

1. Licensure. This item identifies (A) the home care entity that must be licensed, and (B) minimum services that must be provided by the licensed entity. Twenty-eight states use the term "home health agency" as the subject of licensure, and all but Rhode Island define this term to cover only organizations and not individuals or licensed sole practitioners. Other terms

used include: home care agency (DC); home health care provider (ME and NH); home care services agency (NY); and home health care agency (PA).

Minimum service requirements for licensed agencies most commonly reflect the minimum service definition contained in the Medicare conditions of participation, i.e., skilled nursing plus at least one other therapeutic service (physical, speech or occupational therapy; medical social services; or home health aide services). Nine states license agencies that provide only one or more of a list of services. (DE, DC, KS, ME, NH, NY, TN, TX, and VA) Most, but not all states define services as being provided on a part-time or intermittent basis; this dimension of service definition is not included in the table.

2. **Major exemptions.** The exemptions listed in this section of the table are those that significantly exclude agencies or services that would otherwise fall within the definition of organizations covered or minimum services. The most common exemption (19 states) is for care or treatment provided under the tenets of Christian Science and other such recognized churches. The next most frequent exemption (10 states) involves various exclusions for some or all state operated or funded programs.

3. **Bonding/Insurance requirements.** Only four states expressly mandate liability insurance coverage in their licensure statute or regulations (IL, MD, NV and VA) and only one (VA) mandates agency bonding.

4. **Statewide advisory body.** This item lists those states with statutory requirements for statewide home care advisory bodies that include consumer or public membership. Five states have such a requirement (DC, IL, MO, NY and TX). Advisory bodies that oversee all health care facilities or all long-term care services were not included.

5. **Home health aide and/or homemaker training.** Training requirements for home health aides and/or homemakers show very little consistency. Thirteen states include in their licensure law or regulations specific training requirements that include <u>both</u> minimum hours and minimum curriculum requirements or incorporate, by reference a specific community college level curriculum: CA, CT, FL, HI, IL, KS, ME, NY, OR, RI, TN, TX, UT.

6. **Program evaluation and advisory group functions.** Every state with licensure requires some kind of formal agency self-evaluation mechanism, usually on an annual basis at a minimum. Most also require the creation of an ongoing advisory body to participate in the evaluations and, more generally, to advise the agency. This item of the Table identifies two requirements for outside involvement in this process: (A) minimum requirements for the involvement of persons who are neither owners nor employees of the agency (14 states require); and (B) minimum requirements for consumer involvement (16 states require). In most instances, the required level of involvement is minimal (e.g., one or two persons) or undefined.

7. **Consumer rights.** Only twelve states mandate or enumerate a specific list of consumer rights: CA, CT, DC, ID, KS, MD, NV, NY, RI, TX, UT, WS.

8. **Complaint mechanisms.** The existence of mandatory complaint mechanisms usually goes hand-in-hand with mandated consumer rights but not always. Rhode Island and Utah, listed above, do not include complaint procedures in their list of consumer rights; while Missouri and Virginia provide for a complaint mechanism but have no enumeration of consumer rights.

9. **Monitoring agency.** Most states designate their health department or some division within the health department as the entity responsible for licensing and monitoring. The Table lists the authorized department for each state.

10. **Sanctions available.** All states have the authority to deny (or refuse to renew) and to revoke or suspend licenses for failure to comply with licensing rules or standards. Most state licensing entities also have the authority to seek injunctive relief to stop the unlawful operation of a home care agency.

Thirteen states provide for the use of a "provisional" license or its equivalent, which in effect, provides for a time-limited probationary period during which a plan to correct deficiencies must be implemented: DC, ID, KY, ME, MD, MT, NV, NJ, NM, PA, RI, UT, WS.

Six states provide for the use of a "restricted" license or a functionally equivalent procedure which enables the state to restrict or limit new admissions

or services of the agency: AZ, DC, NY, PA, RI, UT.

Six states authorize the imposition of civil fines: AZ, FL, NH, NJ, PA, TX.

Ten states authorize criminal misdemeanor sanctions for operating without a license: AZ, CA, DC, HI, KS, MT, NM, OR, SC, UT.

An additional nine states authorize criminal misdemeanor sanctions for other violations, in addition to operating without a license: AZ, CA, DC, HI, KS MT, NM, OR, SC, UT.

Only one state, Pennsylvania, expressly provides for the intervention of a court appointed receiver (referred to as a "master" in the Pennsylvania statute). Finally, no state expressly granted patient/clients or their representatives a private right of action for enforcement of the licensure law.

TABLE ABBREVIATIONS:

HHA	home health agency
HH Aide	home health aide
H-HHA	homemaker-home health aide
PT	physical therapy
OT	occupational therapy
ST	speech therapy
Med SS	medical social services
Med E&S	medical equipment & supplies
Chr Sci	Christian Science practitioners or related
NR's	nurse registries
adv gr	advisory group

Sanctions:

Den	denial
Sus	suspension
Rev	revocation
Prov	provisional license
Res	restricted license
Civ F	Civil fines
Inj	injunctive relief
Crim	criminal penalties

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	MEDICARE CONDITIONS OF PARTICIPATION 42 C.F.R. §405.1201 et seq. (Subpart L)	ARIZONA Ariz. Rev. Stat. §36-401 et seq. Ariz. Admin. Comp. R9-10-1101 et seq.	CALIFORNIA Health & Safety Code §1725 et seq. Cal. Adm. Code tit. 22, §74600 et seq.
1. Licensure: A. Organizations licensed B. Minimum services	A. Certification: HHA B. Skilled nursing care plus one: PT,OT,ST; Med SS; HH Aide svs	A. HHA B. Skilled nursing svs, plus one: PT,OT,ST, or ST; Med SS; HH Aide scs	A. HHA B. Sk nursing svs plus one: PT, OT, or ST; Med SS; HH Aide svs
2. Major exemptions to Licensure	(Program is voluntary)	Chr Scl	1. Chr Scl 2. HH's
3. Min. Bonding/Insurance Req's	No	No	No
4. Statewide advisory body involving consumers/public	No	No	No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	No	No	Yes
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. Yes (one member of adv gr) B. Yes (unspecified)	A. Yes (one-fourth of adv gr) B. No	A. Yes (one member of adv gr) B. Yes (unspecified)
7. Consumer rights enumerated	No	No	Yes
8. Complaint mechanism mandated	No	No	Yes
9. Monitoring Agency	Health Care Financing Admin. through state survey agency	Dept. of Health Svs	Dept. of Health Svs
10. Sanctions available	Denial or decertification	Den, Sus, Rev, Res, Civ F, Inj, Crim	Den,Sus,Rev,Inj,Crim

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	CONNECTICUT Conn. Gen. Stat. §19a-490 et seq. Conn. Agencies Regs. §19-13-D66 et seq.			DELAWARE Del. Code Ann. tit. 16, §122(3)(h) Regulations Pending[2/]
1. Licensure: A. Organizations licensed B. Minimum services	A. HHA B. Prof'l nursing plus one: H-HHA; PT, OT or ST; Med SS	A. H-HHA agency (Separately licensed)	A. Coordination, Assessment & Monitoring Agency (separately licensed)	A. HHA B. Either 1. HH Aide svs exclusively; or 2. Licensed nursing plus one: HH Aide; PT, OT, or ST; Soc svs; or 3. HH Aide svs plus one: Licensed nursing; PT,OT or ST;Soc svs
2. Major exemptions to Licensure		Any institution wholly supported by the state		Chr Sci
3. Min. Bonding/Insurance Req's		No		No
4. Statewide advisory body involving consumers/public		No[1/]		No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum		Yes		No
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated		A. Yes (all members of adv gr) B. Yes (2 on adv gr)		A. No B. No
7. Consumer rights enumerated		Yes		No
8. Complaint mechanism mandated		Yes		No
9. Monitoring Agency		Dept of Health Svs		Board of Health
10. Sanctions available		Den, Sus, Rev, Inj, Crim (w/o lic)		Not specified

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	DISTRICT OF COLUMBIA D.C. Code Ann. §32-1301 et seq. Regulations pending[2/]	FLORIDA Fla. Sta. §400.461 et seq. Fla. Admin. Code §10D-68.001 et seq.
1. Licensure: A. Organizations licensed B. Minimum services	A. Home Care Agency B. Any program of health care, habilitative or rehabilitative therapy, personal care svs, homemaker svs, or other supportive svs	A. HHA B. Case management by an R.N. plus one: Nursing care; PT, OT, or ST; Med SS, Homemaker, HH Aide, and nutritional guidance; Med E&S
2. Major exemptions to Licensure	(1) Nonmedical svs by or through a relig org on a small-scale volunteer basis. (2) Agency operated by the federal govt. (3) Chr Sci	Any agency or organization operated by the federal govt.
3. Min. Bonding/Insurance Req's	No	No
4. Statewide advisory body involving consumers/public	Advisory Task Force (numbers not specified)	No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	No	Yes
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. No B. No	A. No B. No
7. Consumer rights enumerated	Yes	No
8. Complaint mechanism mandated	Yes	No
9. Monitoring Agency	Dept. of Consumer & Regulatory Affairs	Dept of Health & Rehabilitative Svs
10. Sanctions available	Den, Sus, Rev, Prov, Rec, Inc, Crim	Den, Sus, Rev, Inj, Civ P, Conditional lic. (if lic. expiration occurs during rev. or sus. proceedings)

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	GEORGIA Ga. Code §31-7-150 et seq. Ga Admin. Comp. ch. 290-5-38	HAWAII Hawaii Rev. Stat. §§321-11, 321-18 Hawaii Admin. Rules §11-97-1 et seq.	IDAHO Idaho Code §39-1301 et seq. Idaho Admin. Regs. tit. 2, ch. 5
1. Licensure: A. Organizations licensed B. Minimum services	A. HHA[3/] B. Skilled nursing plus one: PT, OT, or ST; Med SS, HH Aide svs	A. HHA B. Skilled nursing svs plus one: PT;OT;ST; Med SS; HH Aide svs	A. HHA (Proprietary only) B. Skilled nursing plus one: PT; OT; Soc svs, Nutrition; H-HH Aide, Med E&S; and related svs
2. Major exemptions to Licensure	None	None	(1) Non-profit agencies (2) Chr Sci
3. Min. Bonding/Insurance Req's	No	No	No
4. Statewide advisory body involving consumers/public	No	No	No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	No	Yes[4/]	No
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. Yes (one on adv gr) B. Yes(unspecified)	A. No B. Yes (adv gr must include community members)	A. No B. Yes (unspecified no. on adv gr)
7. Consumer rights enumerated	No	No	Yes
8. Complaint mechanism mandated	No	No	Yes
9. Monitoring Agency	Dept of Human Resources	Dept. of Health	Dept of Health & Welfare
10. Sanctions available	Den, Sus, Rev, Crim (w/o lic)	Den, Sus, Rev, Crim	Den, Sus, Rev, Prov, Inj, Crim (w/o lic)

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	ILLINOIS Ill. Ann. Stat. ch. 111 1/2, §2801 et seq. Ill. Admin. Code tit. 77, §245	KANSAS Kan. Stat. Ann. §65-5101 et seq. Kan. Admin. Regs. §28-51-100 et seq.
1. Licensure: A. Organizations licensed B. Minimum services	A. HHA B. Nursing svs plus one: PT, OT, ST, Med SS; HH Aide svs	A. HHA B. Any one or more: Nursing; PT; ST; Nutritional or dietetic consulting; OT; RT; HH Aide svs, Med SS
2. Major exemptions to Licensure	Chr Sci	(1) Local health depts. which are not federally certified HHA's (2) Dept. of Social & Rehabilitation Svs and Dept of Health & Environment (3) Chr Sci
3. Min. Bonding/Insurance Req's	Liab insurance	No
4. Statewide advisory body involving consumers/public	Home Health Advisory Comm. (5 members, 3 from general public)	No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	Yes	Yes
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. No B. No	A. No B. No
7. Consumer rights enumerated	No	Yes
8. Complaint mechanism mandated	No	Yes
9. Monitoring Agency	Dept. of Public Health	Dept of Health & Environment
10. Sanctions available	Den, Sus, Rev, Inj	Den, Sus, Rev, Inj, Crim

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	KENTUCKY Ky. Rev. Stat. §216B 902 Ky. Admin. Regs. 20:081	LOUISIANA La. Rev. Stat. Ann. §40:2009.31 et seq. Regulations Pending[2]
1. Licensure: A. Organizations licensed B. Minimum services	A. HHA B. Skilled nursing svs and HH Aide svs and Med S&S	A. HHA B. Skilled nursing plus one: PT, OT, or ST; HH Aide; Med SS
2. Major exemptions to Licensure	Chr Sci	Office of Elderly Affairs services to the elderly
3. Min. Bonding/Insurance Req's	No	No
4. Statewide advisory body involving consumers/public	No	No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	No	No
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. No B. No	A. No B. No
7. Consumer rights enumerated	No	No
8. Complaint mechanism mandated	No	No
9. Monitoring Agency	Health Facilities and Health Svs COM & Licensure Bd.	Dept. of Health & Human Resources
10. Sanctions available	Den, Sys, Rev, Prov, Inj, Crim (w/o lic)	Den, Rev, Crim

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS
AND REGULATIONS GOVERNING HOME CARE

	MAINE Me. Rev. Stat. Ann. tit. 22, §2141 et seq. Regs. Governing Home Health Care Svs	MARYLAND Md. [Health-General] Code Ann. §19-401 et seq. Md. Admin. Code tit. 10, §10.07.10
1. Licensure: A. Organizations licensed B. Minimum services	A. Home Health Care Provider (or Agency) B. Any one or more: Prof'l nursing; PT; Speech path; HH Aides; Nurse assistants; Med soc work; Nutritionist svs; Personal care svs	A. HHA B. Skilled nursing and HH Aide svs, plus one more approved by the state: Audiology & speech path; Dietary & nutritional svs; Drug svs; Laboratory; Med SS; OT; PT; Med E&S
2. Major exemptions to Licensure	(1) Elderly nutrition programs (2) State govt. departments (3) Municipal entities	(1) Chr Sci (2) HH's
3. Min. Bonding/Insurance Req's	No	Liab insurance
4. Statewide advisory body involving consumers/public	No	No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	Yes	No
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. No B. No	A. No B. Yes (one public member on adv gr)
7. Consumer rights enumerated	No	Yes
8. Complaint mechanism mandated	No	Yes
9. Monitoring Agency	Dept. of Human Svs	Dept of Health & Mental Hygiene
10. Sanctions available	Den, Sus, Rev, Conditional lic	Den, Sus, Rev, Prov, Crim (w/o lic)

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS
AND REGULATIONS GOVERNING HOME CARE

	MISSOURI Mo. Ann. Stat. §197.400 et seq. Regulations Pending[2/]	MONTANA Mont. Code Ann. §50-5-101 et seq. Mont. Admin. R. Sub-ch. 3, rule 16.32.307 et seq.
1. Licensure: A. Organizations licensed B. Minimum services	A. HHA B. Any two or more: Nursing; PT; ST; OT; HH Aide; Med SS	A. HHA[6/] B. Skilled nursing care plus one: PT, OT, ST; Med SS; HH Aide svs.
2. Major exemptions to Licensure	Chr Sci	Chr Sci
3. Min. Bonding/Insurance Req's	No	No
4. Statewide advisory body involving consumers/public	Home Health Svs Advisory Council (Incl. 3 citizens with no connection to any HHA)	No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	No	No
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. No B. No	A. Yes (one member of adv gr) B. Yes (unspecified)
7. Consumer rights enumerated	No	No
8. Complaint mechanism mandated	Yes[2/]	No
9. Monitoring Agency	Div. of Health, Dept. of Social Svs	Dept. of Health & Environmental Svs
10. Sanctions available	Den, Sus, Rev, Inj	Den, Sus, Rev, Prov, Inj, Crim

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	NEVADA Nev. Rev. Stat. §449.001 et seq. Nev. Admin. Code §449.010 et seq.	NEW HAMPSHIRE N.H. Rev. Stat. Ann. §151.1 et seq. N.H. Admin. Code ch. He-P 809	NEW JERSEY N.J. Stat. Ann. §26:1A-1 et seq. Standards for Lic. of HAA's
1. Licensure: A. Organizations licensed B. Minimum services	A. HHA B. Skilled nursing and Homemaker and HH Aide svs svs; Homemaker svs.	A. Home Health Care Provider B. Any one or more: Nursing svs; HH Aide; PT & OT; Speech pathology; nutritional svs; Med SS; Personal Care (lic may be classified by service)	A. HHA B. Profl nursing svs and Homemaker-HH Aide svs and PT
2. Major exemptions to Licensure	(1) Chr Sci	(1) Svs pursuant to Older Americans Act, Title III(c) Nutrition programs under Soc Svs Block Gr. or under a private charity (3) Chr Sci	Chr Sci
3. Min. Bonding/Insurance Req's	Liab insurance	No	No
4. Statewide advisory body involving consumers/public	No	No	No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	No	No	No[1/]
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. Yes (all members of adv gr) B. Yes (2 members of adv gr)	A. No B. No	A. Yes (at least one member on adv gr) B. Yes (a lay person knowledgeable in health affairs on adv gr)
7. Consumer rights enumerated	Yes	No	No
8. Complaint mechanism mandated	No	No	No
9. Monitoring Agency	State Board of Health	Div. of Public Health Svs	Dept. of Health
10. Sanctions available	Den, Sus, Rev, Pro, Inj, Crim (w/o lic)	Den, Sus, Rev, Reclassification of lic., Inj, Civ F, Crim (w/o lic)	Den, Sus, Rev, Prov, (or Probationary lic), Inj, Civ F

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	NEW MEXICO N.M. Stat. Ann. §24-1-1 et seq. Home Health Agency Licensing Regs.	NEW YORK N.Y. [Public Health] Law §3600 et seq. N.Y. Admin. Code tit. 10, §765-767
1. Licensure: A. Organizations licensed B. Minimum services	A. HHA B. Skilled nursing svs plus one: HH Aide; Med soc. worker svs; PT; OT; Speech and language ther svs	A. Home Care Svs Agency [10] B. Any one or more: Nursing; HH Aide; PT, ST, and OT; Nutritional svs; Med SS; Personal care svs; Homemaker svs; Housekepper or chore svs
2. Major exemptions to Licensure	None	(1) Programs exclusively administered, operated or regulated by another state agency. (2) NR's
3. Min. Bonding/Insurance Req's	No[9]	No
4. Statewide advisory body involving consumers/public	No	State Council on Home Care Svs (27 members, incl 8 public representatives)
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	No	Yes
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. No B. Yes (unspecified)	A. No B. No
7. Consumer rights enumerated	No	Yes
8. Complaint mechanism mandated	Yes	Yes
9. Monitoring Agency	Health & Social Svs Dept	Dept of Health
10. Sanctions available	Den, Sus, Rev, Prov[9], Crim	Den, Sus, Rev, Limited lic, Annul

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	NORTH CAROLINA N.C. Gen. Stat. §131E-135 et seq. N.C. Admin. Code Sub-ch 3L	NORTH DAKOTA N.D. Cent. Code §23-17.3-01 et seq. N.D. Admin. Code §33-03-10	OREGON Or. Rev. Stat. §443 Or. Admin. R. ch 333, div. 27
1. Licensure: A. Organizations licensed B. Minimum services	A. HHA B. Nursing svs plus one: PT, OT or ST; Med SS, HH Aide, and other ther. svs; Med E&S	A. HHA B. Svs of licensed R.N. plus one: PT, OT, or ST; Med SS; HH Aide; RT	A. HHA B. Skilled nursing svs plus one: PT, OT, or ST; Med SS; Other ther. svs; HH Aide svs; Med E&S
2. Major exemptions to Licensure	Public agencies and county and district health depts.	None stated	(1) Chr Sci (2) Certain HH svs offered by county health depts (3) Hospitals offering HH svs, as long as lic. standards are met.
3. Min. Bonding/Insurance Req's	No	No	No
4. Statewide advisory body involving consumers/public	No	No	No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	No	No	Yes
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. No B. No	A. No B. No	A. Yes (2 on adv gr) B. Yes (2 on adv gr)
7. Consumer rights enumerated	No	No	No
8. Complaint mechanism mandated	No	No	No
9. Monitoring Agency	Dept. of Human Svs	Dept. of Health	Health Div, Dept of Human Resources
10. Sanctions available	Den, Sus, Rev, Inj, Annul, Withdraw, Recall, Cancel, Amend	Den, Sus, Rev	Den, Sus, Rev, Crim

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	PENNSYLVANIA PA. Stat. Ann. tit. 35,§448.801 et seq. Regulations Pending[2/]	RHODE ISLAND R.I. Gen. Laws §23-17-1 et seq. R23-17-HHA	SOUTH CAROLINA S.C. Code Ann. §44-69-10 et seq. Dept of Health & Env. Control Reg. No.61-77
1. Licensure: A. Organizations licensed B. Minimum services	A. Home Health Care Agency [11/] B. Nursing plus one ther svc (unspecified)	A. HHA (includes a person) B. Nursing svs and HHA svs plus one: Nutrition; OT & PT; Med soc work; ST; and other related health and supportive svs	A. HHA Skilled nursing plus one: PT, OT, or ST; Med SS; Med E&S
2. Major exemptions to Licensure	Chr Sci	(1) Facilities licensed by the Dept of Mental Health, Retar. and Hosp; or by the Dept of Social & Rehab Svs (2) Chr Sci	None
3. Min. Bonding/Insurance Req's	No	No	No
4. Statewide advisory body involving consumers/public	No	No[12/]	No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	No	Yes	No
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. No B.No	A. Yes (one on adv gr) B. No	A. Yes (one on adv gr) B.No
7. Consumer rights enumerated	No	Yes	No
8. Complaint mechanism mandated	No	No	No
9. Monitoring Agency	Dept of Health	Dept of Health	Dept of Health & Env. Control
10. Sanctions available	Den, Sus, Rev, Prov, Susp of Admis Inj, Civ P, Appt of a master	Den, Sus, Rev, Prov[13/], Res,[13/] Inj	Den, Sus, Rev, Crim

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS
AND REGULATIONS GOVERNING HOME CARE

	TENNESSEE Tenn. Code Ann. §53-1301 et seq. Tenn. Admin. Comp. ch 1200-8-8	TEXAS Tex. Civ. Stat. Ann., art. 4447u Tex. Admin. Comp. §115.1 et seq.
1. Licensure: A. Organizations licensed B. Minimum services	A. HHA B. One or more: Skilled nursing care; PT, OT, or ST; Med SS; HH Aide and Homemaker svs; Med E&S	A. HHA[14/] One or more: Nursing; PT, OT, ST, or RT; Med SS HH Aide svs; Med E&S; Nutritional counseling
2. Major exemptions to Licensure	(1) State/local gov't HHA's (may be excluded) (2) HHA's operated by federal gov't (3) Chr Sci (4) HMO's	(1) Chr Sci (2) Pharmacy or med equip co. (3) Durable med. equip co. (4) Certain non-profit referral registries
3. Min. Bonding/Insurance Req's	No	No
4. Statewide advisory body involving consumers/public	No	HH Svs Advisory Council (9 members, 2 consumers)
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	Yes	Yes
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. Yes (majority of adv gr) B. Yes (one on adv gr)	A. No[14/] B. No[14/]
7. Consumer rights enumerated	No	Yes
8. Complaint mechanism mandated	No	Yes
9. Monitoring Agency	Dept of Public Health	Dept of Health
10. Sanctions available	Den, Sus, Rev, Inj, Crim (w/o lic)	Den, Sus, Rev, Inj, Civ P

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	UTAH Utah Code Ann. §26-21-1 et seq. Dept of Health HHA Rules	VIRGINIA VA Code §32.1-162.7 et seq. Regulations pending[2/]
1. Licensure: A. Organizations licensed B. Minimum services	A. HHA B. Skilled nursing plus one: PT, ST, OT; Med SS; HH Aide	A. HHA B. One or more: Skilled nursing; PT, OT, or ST; Med SS; HH Aide svs; Med E&S; Specialized nutrition support; I-V therapy, and RT.
2. Major exemptions to Licensure	None	Medicare or Medicaid HHA's
3. Min. Bonding/Insurance Req's	No	Liab insurance and bond
4. Statewide advisory body involving consumers/public	No[1/]	No[1/]
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	Yes	No
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. No B. No	A. No B. No
7. Consumer rights enumerated	Yes	No
8. Complaint mechanism mandated	No	Yes
9. Monitoring Agency	Dept of Health	Dept of Health
10. Sanctions available	Den, Sus, Rev, Prov, Restrict new admiss, Conditional lic, Crim.	Den, Sus, Rev, Inj

COMPARISON OF SELECTED ASPECTS OF STATE LICENSURE LAWS AND REGULATIONS GOVERNING HOME CARE

	WASHINGTON Wash. Rev. Code ch 70.126 Wash. Admin. Code ch. 248-27	WISCONSIN Wis. Stat. §141.15 Wis. Admin. Code ch. HSS 133
1. Licensure: A. Organizations licensed B. Minimum services	A. HHA[1]/ B. Registered nurse svs, plus one: PT; OT; ST; HH Aide svs	A. HHA B. Nursing svs and HH Aide svs
2. Major exemptions to Licensure	None	None
3. Min. Bonding/Insurance Req's	No	No
4. Statewide advisory body involving consumers/public	No	No
5. HH Aide and/or Homemaker Training: mandates minimum hours and approved curriculum	No	No
6. Program evaluation and/or advisory group functions: A. Non-employee/non-owner involvement mandated B. Consumer involvement mandated	A. Yes (one-third of adv gr) B. Yes (unspecified)	A. Yes (majority of adv gr) B. Yes (unspecified)
7. Consumer rights enumerated	No	Yes
8. Complaint mechanism mandated	No	Yes
9. Monitoring Agency	Dept of Social and Health Svs	Dept of Health and Social Svs
10. Sanctions available	Den, Sus, Rev	Den, Sus, Rev, Prov, Probationary lic, Inj, Crim (w/o lic)

1/ CT has a statewide Advisory Body on Long-Term Care which includes at least two consumers.

2/ Because regulations implementing the statute are not final, the items marked "No" are subject to change.

3/ GA grants deemed status to Medicare/Medicaid certified agencies.

4/ The Hawaii regulations do not specify hours or curriculum, but HH Aide is defined as a person who has "completed the basic prescribed nurse aide course in the community college system; or an equivalent course. . ."

5/ Only for complaints meriting possible suspension or revocation of license (MO)

6/ Montana expressly incorporates the Medicare conditions of participation as its licensure standards.

7/ N.J. regulations require completion of a training program in personal care services approved by the Dept of Health, but neither hours nor curriculum are specified.

8/ N.M. regulations recommend liability insurance coverage but do not require it.

9/ N. M. uses the term "temporary license."

10/ The New York statute also sets forth separate certification requirements applicable to HHA's certified under Medicare and Medicaid.

11/ PA grants deemed status to Medicare/Medicaid certified agencies

12/ R.I. has a statewide Health Services Council relating to all health care facilities including HHA's. No consumer involvement is mandated.

13/ The R.I. statute provides for sanctions that function as provisional and restricted licenses, but the terms "provisional" and "restricted" are not used.

14/ Texas provides for two classes of licensure: Class A for Medicare certified HHA's and Class B for all other HHA's. Class A licenses should have non-employee/non-owner and consumer involvement in program evaluation per the Medicare regulations.

15/ Utah law establishes an 11 member Health Facilities Committee with oversight responsibility for all health facilities in the state, including HHA's. Three consumers are mandated on this committee.

16/ The VA statute creates a Home Health Svs Advisory Committee, but there is no required consumer involvement.

17/ Washington law refers to its HHA regulatory requirements as "certification," but it is treated here as a licensure.